SFAC

ADDRESS CHANGE REQUEST FORM

Please fill out all information completely. Sign, date and mail form to: Kentucky Department of Labor, Division of Worker's Compensation Funds, 1047 US Hwy 127 South, Ste. 2, Frankfort, KY 40601. Please allow up to 4 weeks for the address change to take effect. .

CLAIM NUMBER: _____

CLAIMANT'S NAME: _____SS#_____

ADDRESS: _____

_____

TELEPHONE NUMBER: ( ) _____

SIGNATURE OF PAYEE: _____ **DATE**: _____